

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM  
**ANDROGENS** (all dosage forms)

Patient name: \_\_\_\_\_ Medicaid ID #: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_ Prescriber NPI#: \_\_\_\_\_ Contact person: \_\_\_\_\_

Prescriber Phone#: \_\_\_\_\_ Extension/Option: \_\_\_\_\_ Fax#: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Pharmacy Phone#: \_\_\_\_\_ Pharmacy Fax #: \_\_\_\_\_

Requested Medication: \_\_\_\_\_ Strength: \_\_\_\_\_ Frequency/Day: \_\_\_\_\_

**All information to be legible, complete and correct or form will be returned**

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**FAX DOCUMENTATION FROM PROGRESS NOTES  
OR IN LETTER OF MEDICAL NECESSITY TO 855-828-4992**

**CRITERIA:**

- Androgens for Females:
  - Only FDA-approved uses will be considered. Only testosterone enanthate (Danazol<sup>®</sup>) will be authorized. Please submit appropriate documentation describing one of the following:
    - Hormone-responsive endometriosis
    - Trial and failure of at least one other treatment for fibrocystic breast disease
    - Trial and failure of at least one other treatment for hereditary angioedema
- Androgens for Males:
  - ≥ 18 years old
  - Diagnosis of anterior pituitary hormone deficiency or testicular hypofunction
  - Symptoms of testosterone deficiency
  - Two morning testosterone levels below the individual lab's reference range (different laboratories use different assays and thus may have different ranges which are considered low, optimal, or high)

**INITIAL AUTHORIZATION:** 6 months

**RE-AUTHORIZATION:** 1 year at a time.

- Females: Requests must be accompanied by progress notes or a letter of medical necessity justifying continued therapy. Therapy must be for an FDA-approved use.
- Males: Requests must be accompanied by one morning testosterone level, drawn while receiving androgen therapy, in order to verify drug absorption. Labs drawn while off androgen therapy will not be accepted. If labs are not obtained while on androgen therapy, the patient must wait 6 months (androgen free) before re-applying for a new authorization.